STATE OF VERMONT
AGENCY OF HUMAN SERVICES

P A T H

Department of Prevention, Assistance, Transition, and Health Access

B U L L E T I N NO.: 02-34

FROM: Eileen I. Elliott, Commissioner
for the Secretary

DATE: 9/5/02

SUBJECT: SFY '03 Deficit Prevention Plan for Medicaid and VHAP: Elimination of adult chiropractic services for Medicaid and VHAP, elimination of adult dentures for Medicaid, and elimination of elective hospital inpatient admissions for VHAP

CHANGES ADOPTED EFFECTIVE 11/1/02

INSTRUCTIONS

_X_ Maintain Manual - See instructions below.

___ Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____

___ Information or Instructions - Retain until _____

MANUAL REFERENCE(S):

M621 4001.92
M640 4003

The SFY '03 Deficit Prevention Plan, which was authorized by Act 142 of 2002 and approved by the Joint Fiscal Committee of the Vermont General Assembly, calls for certain changes in Medicaid and VHAP coverage. This rule proposes to eliminate coverage of chiropractic services for VHAP and Medicaid adults. The rule also proposes to suspend indefinitely coverage of dentures for adults as of 11/1/02, effectively eliminating the benefit. Finally, the rule would limit VHAP coverage of inpatient hospital care to emergency and urgent admissions only (eliminating elective admissions). Elective admissions are defined as when "the patients condition permits adequate time to schedule the availability of a suitable accommodation." The admitting physician will decide when a hospital admission is emergency, urgent, or elective.

Specific Changes to Existing Regulations

4001.92 Removes chiropractic services from the list of benefits with a cost-sharing requirement.

4003 Coverage of inpatient hospital care was reduced to urgent and emergent admissions only by change in PATH Procedures. This change eliminates referral requirement for elective admissions and no longer identifies chiropractic services as a wrap-around benefit.

M621 Eliminates coverage of dentures for adults as of 11/1/02.

M640 Limits coverage of chiropractic services to beneficiaries under age 21 only.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing regulation content.

Three dots at the bottom of a page after the last line of text and three dots at the top of the following page before the first line of text indicate that text has been moved.

Manual Holders: Please maintain manuals assigned to you as follows.

Manual Maintenance

VHAP Policy

Remove		Insert	
4001.92	(02-22)	4001.92	(02-34)
4003	(98-23F)	4003	(02-34)
4003.1	(02-22F)	4003.1	(02-34)

Medicaid Policy

M621	(99-12)	M621	(02-34)
M621.4 P.2	(98-11F)	M621.4 P.2	(02-34)
M640	(84-07)	M640	(02-34)

4001 Eligibility

4001.9 Cost Sharing in Fee-for-Service and Managed Care

4001.92 Copayment

Copayments from individuals receiving VHAP are required for certain services. Section 1916(c) of the Social Security Act stipulates that "no provider participating under the State [Medicaid] plan may deny care or services to an individual eligible for [Medicaid]... on account of such individual's inability to pay [the copayment]." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of [the copayment]." This federal statute does not apply to coinsurance, such as coinsurance for prescription drugs.

Service-specific cost-sharing liabilities are:

Physician services:	$7.00 copayment per visit
Other practitioner services:	$7.00 copayment per visit
Physical, occupational, speech and nutrition therapy services:	$7.00 copayment per visit
Hospital Inpatient	$ 50.00 copayment per admission
Outpatient hospital services not including ER services:	$25.00 per day per hospital
Emergency room:	$25.00 per visit but $60.00 if visit is not a medically necessary emergency, as defined in M103.3 (13) and (37)
Prescription drugs:	60 percent coinsurance per prescription or refill or 50 percent coinsurance when enrolled in managed health care plan. NOTE: Failure to pay the co-insurance can result in denial of service.

Coinsurance payments are limited to a calendar year maximum of $750 for a single person and $1,500 for VHAP families, when the individual or family is in managed care. The managed health care plan is responsible for letting the individual or family know when they have reached their annual out-of-pocket maximum.

No copayments or coinsurance is required for pregnant women or women in the 60-day post-pregnancy period.

4003 Benefit Delivery Systems

While enrollment in a managed health care plan will be mandatory for VHAP participants, covered services for eligible beneficiaries may be provided using a fee-for-service payment system until adequate managed care capacity is developed.

As managed care capacity becomes available in a given area, VHAP participants will be transferred into available managed care slots.

For beneficiaries required to enroll in managed health care plans, no payment will be made for services obtained outside the plan except for covered services designated as wrap-around services. (See 4003.1)

4003.1 Benefits

The VHAP-Limited benefit packages (limited and managed care) are described in procedures found at P-4003.

VHAP beneficiaries enrolled in managed health care plans can access services through the following ways:

A. Services Requiring Plan Referral

In VHAP managed care the following services, must have a referral from the beneficiary's primary care provider.

- inpatient hospital care (emergency and urgent admissions only, as determined by the admitting physician);
- outpatient services in a general hospital or ambulatory surgical center;
- physician services;
- maxillofacial surgery;
- cornea, kidney, heart, heart-lung, liver and bone marrow transplants, including expenses related to providing the organ or doing a donor search;
- home health care;
- hospice services by a Medicare-certified hospice provider;
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy);
- prenatal and maternity care;
- ambulance services;
- medical equipment and supplies;
- skilled nursing facility services for up to 30 days length of stay per episode;

4003 Benefit Delivery Systems

4003.1 Benefits

A. Services Requiring Plan Referral (Continued)

- mental health and chemical dependency services;
  NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.
- podiatry services;
- prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
- over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

B. Self-Referral Services

In VHAP managed care the following services may be accessed by beneficiaries without a referral from their primary care provider.

- one routine annual gynecological exam and related diagnostic services (as specified by the plan);
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
- one routine eye examination every 24 months. (Coverage is suspended from July 1, 2002 to June 30, 2003)

C. Wrap-Around Benefits

In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:

- Coverage of limited dental services ends on the later of December 1, 2001, or the Centers for Medicare and Medicaid Services' (CMS), formerly the Health Care Financing Administration, approval date for the elimination of these services from VHAP wrap-around benefits: dental services, excluding dentures, up to an annual calendar-year benefit maximum of $475.
- eyeglasses furnished through PATH's sole source contractor (Coverage is suspended from July 1, 2002 to June 30, 2003);
- family planning services (defined as those services that either prevent or delay pregnancy).

M621 Dental Services for Beneficiaries Age 21 and older

M621.1 Definition

Dental services are preventive, diagnostic, or corrective procedures involving the oral cavity and teeth. This definition was taken from the federal definition found at 42 CFR § 440.100.

M621.2 Eligibility for Care

As of January 1, 1989, coverage of dental services was extended to beneficiaries age 21, or older.

M621.3 Covered Services

Services that have been pre-approved for coverage are limited to:

Dental services:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis;
- limited periodontal therapy;
- treatment of injuries;
- oral surgery for tooth removal and abscess drainage;
- endontics (root canal therapy);
- restoration of decayed teeth.

M621.4 Conditions for Coverage

Coverage of dental services for adults is limited to a maximum dollar amount per beneficiary per calendar year. The current maximum dollar amount is $475.

M621 Dental Services for Beneficiaries Age 21 and older

M621.4 Conditions for Coverage (Continued)

Non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

Coverage of prophylaxis is limited to once every six months, except more frequent treatments can be authorized by the department's dental consultant.

Endodontic treatment is limited to Medicaid payment for three teeth per lifetime.

Approval granted by the department's dental consultant assures medical necessity and coverage.

M621.5 Prior Authorization Requirements

Prior authorization by the PATH Dental Consultant is required for most special dental services. The Provider Manual contains a detailed list of procedures, their codes, and fee schedule. It also indicates which procedure codes require prior authorization.

M621.6 Non-Covered Services

Unless authorized for coverage via M108, services that are not covered include: cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

M640 Chiropractic Services

Services furnished by a licensed chiropractor certified to meet the standards for participation in Medicare are covered for beneficiaries under age 21 only.

Coverage is limited to treatment by means of manipulation of the spine and then only if such treatment is to correct a subluxation of the spine.

The existence of the subluxation may be demonstrated by means of:

1 . An x-ray taken at a time reasonably proximate to the initiation of the course of treatment, or

2. Adherence to the clinical review criteria developed by the Vermont Chiropractic Association and the Vermont Medicaid Program. A copy of the clinical review record must be kept on file by the chiropractor and be made available upon request.

An x-ray will be considered "reasonably proximate" if:

In the case of a low grade chronic subluxation complex, it is taken no more than 12 months prior to the initiation of the course of treatment. A re-evaluation x-ray must be performed before the beginning of the third year of continuous care; or

In the case of an acute subluxation, it is taken no earlier than three months prior to the initiation of care (This would justify a course of treatment for a maximum of three months.)

Medicaid does not cover an x-ray ordered solely for the purpose of demonstrating a subluxation of the spine. Any charges incurred for the chiropractic x-ray must be borne by the recipient, recipient's family, friends or such other community resources as may be available.

Chiropractic services for recipients under the age of 12 require prior authorization from the Medical Review Unit, Medicaid Division, Waterbury. Clinical review data pertinent to the need for treatment must be submitted in writing.

Coverage is limited to ten treatments per patient per calendar year. Exceptional or unusual circumstances may justify a request by the chiropractor for additional coverage. Requests must contain full clinical data, x-rays or other documentation as may be required by the Medicaid Medical Review Unit, Medicaid Division, Waterbury, to evaluate the medical necessity for continued care.

Payment for chiropractic treatment will be made at the lower of the actual charge or the Medicaid rate on file.